STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A006	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANNE JUGAN RESIDENCE	185 SALEM CHURCH ROAD NEWARK, DE 19713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from June 18, 2012 through June 21, 2012. The deficiencies contained in this report are based on observations, interviews, review of resident's records and review of other documentation as indicated. The facility census the first day of the survey was 38. The Stage II sample totaled 26 residents.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Le Cecile Zeringue	adm	7/13/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility documents and interview, it was determined that the facility failed to ensure that an incident which had the potential for abuse and/or neglect for one (R5) out of 26 sampled residents was thoroughly investigated. Findings include: R5 was admitted to the facility on 2/2/10 and had a diagnosis that included dementia. The 5/29/12 quarterly Minimum Data Set (MDS) assessment stated R5 had severe cognitive impairment (Brief Interview for Mental Status score=06), required extensive assist of one staff for transfers and limited assist of one staff for toilet use. Review of the facility "Accident or Incident Report," dated 6/3/12 stated "Resident let go of hand rails while standing in bathroom, lost balance and fell. Braced fall with (left) arm, c/o (complained of) severe pain and limited ROM (range of motion)." The incident report stated that E17 (Certified Nurse's Aide) was a witness to the accident. Review of facility documents related to the incident lacked evidence that a statement had been obtained from E17 pertaining to the events	F 225	R5 (Resident) and E17(CNA) verbalized to the nurse immediately after the incident on 6/3/2012 what had occurred. During investigation of the incident R5 and E17 gave a verbal report to the DON of what had happened to cause the incident. The report given to the DON and the nurse by R5 and E17 matched. While R5 does have a diagnosis of dementia she was able to verbalize what had happened immediately after the incident. As it was determined that abuse did not occur, the investigation was concluded. A report was sent to the state: as recommended for falls with injury regarding the incident. All Residents have the potential to be affected by abuse. At Jeanne Jugan Residence abuse is not tolerated. Strict Abuse Prevention Policies and Procedures have always been in place to protect our Residents. All staff are in serviced on hire and annually regarding these policies.	6/3/2012 6/4/2012

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F 225	Continued From page 2 leading up to the accident. The facility failed to thoroughly investigate this fall which had the potential for abuse and/or neglect. In an interview with E2 (Director of Nursing) on 6/21/12, she stated that she had spoken to the resident and E17 after R5's fall and based on the information given to her, she did not feel there was an issue of any abuse and/or neglect. Therefore, she stated she had not obtained written statements from any staff. During an interview with E17 on 6/2/12 at 3:10 PM, she stated that she had told the evening staff nurse what happened, but that she had not written a statement regarding the events. The facility failed to thoroughly investigate the incident.	F 225	The Accident /Incident Report form has been modified to prompt the Charge Nurses to include Witness and Resident statements whenever possible. The revised form was formally introduced at the last Nurses Meeting. *See two sided attachment A* Accident/Incident Report forms will be reviewed weekly during Falls Committee Meetings. Any issues or concerns will be immediately addressed.	6/28/12 7/10/12
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to maintain an environment free from accident hazards as evidenced by an accessible and unlocked maintenance tool cart and a comb/brush sanitizer (Barbicide) container. Findings include:	F 323	On 6/19/12 E7 and all maintenance staff were reminded that the maintenance cart must be in view at all times. The beauty parlor was locked on 6/21/12.	6/19/12 6/21/12

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F 323	Continued From page 3 1. Observation of the St. Joseph second floor hallway on 6/19/12 at 9:25 AM revealed an unlocked and accessible red maintenance tool cart that had its contents accessible to residents for at least 15 minutes. E7 (maintenance staff) was observed in R25's bathroom doing repairs with the cart not within his view. The cart was located in the hallway one room down from R25's room which was not within view. The tools observed inside the unlocked maintenance cart were items such as a saw, screwdrivers, scissors, spackle knife, hammers, and battery powered drill. Screwdrivers and a portable ladder were also observed on the top of the cart easily accessible and within sight. In an interview with R25 on 6/19/12 at 10:00AM, she indicated the maintenance staff was fixing the fan in her bathroom. In an interview with E8 (Nurse) on 6/19/12, she stated that there were three residents (R36, R20 and R2) with memory problems living on that wing and could propel themselves around the unit. On 6/21/12, E7 stated that he started bringing the maintenance cart within his sight after he saw the surveyors looking at the cart. In an interview with E9 (Administrator) and E5 (Maintenance Director) on 6/21/12 at 9:50 AM, findings were acknowledged. 2. Observation of the facility beauty parlor on 6/20/12 at 3:30 PM and 6/21/12 at 7:45 AM revealed the door to the room was unlocked and it's contents accessible to residents. A container	F 323	All residents have the potential to be affected by potential accident hazards in the environment. Locking the Beauty Parlor when not in use , and keeping Barbicide comb and brush cleaner in a locked cabinet have been added to the safety checklist. *See attachment B* Ensuring the maintenance cart is within a staff members view at all times or in a locked room has been added to the safety checklist. *See attachment C* Safety Checklist will be reviewed monthly by the Maintenance Director and Quarterly by the Safety Committee	7/1/12 7/1/12 7/10/12

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F 323	Continued From page 4 of Barbicide (sanitizer for combs/brushes) was observed in an unlocked cabinet under the hair sink.	F 323		
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed to ensure that one (R30) out of 10 residents sampled during the medication pass observation was free of significant medication errors. Findings include: R30 was readmitted to the facility post hospitalization on 6/15/12 with diagnoses that included atrial fibrillation (heart rhythm disorder), coronary artery disease and hypertension. Physician's readmission orders, dated 6/15/12, stated R30 was to receive Amlodipine 5 mg daily. Amlodipine is used for the treatment of hypertension and certain types of chest pain. On 6/21/12 at 8:30 AM, E12 (nurse) was observed administering R30's morning medications. E12 poured and administered one Amlodipine 2.5 mg tablet, along with other medications that were due. Upon reconciliation of R30's medications with the physician order sheet, it was found that R30 was ordered to receive Amlodipine 5 mg daily (not 2.5 mg). Further review of physician's orders revealed that prior to hospitalization, R30 was receiving Amlodipine 2.5	F 333	R30's physician was called as soon as the error was noted. Upon review of the Blood Pressures the medication was reduced. The Resident was not caused any discomfort, Blood Pressures in fact remained in normal to low limits.	6/21/12
			All Residents returning from the hospital have the potential to be affected by medication errors.	7/6/12
			Reviewing medications in the medication cart and removing any medications not ordered has been added to the Admission Checklist to be completed immediately on admission.	6/28/12
			The new Admission checklist was formally introduced at the last Nurses Meeting.	7/10/12
			See attachment D	
			Ensuring that any medications which are not ordered are not in the med cart has been added to the QAPI Admission checklist which is to be completed by a administrative nurse 72 hours after admission and any issues will be reviewed at quarterly QAPI Meetings	6/28/12
			See attachment E	

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F 333	Continued From page 5 mg daily and upon return to the facility, the dose was increased to 5 mg daily. Review of the medication administration record (MAR) from 6/16/12 through 6/21/12 revealed that Amlodipine 5 mg 1 tablet daily was signed off as having been administered. During a subsequent interview with E12, she acknowledged that she had poured and administered Amlodipine 2.5 mg 1 tablet to R30 during the AM medication pass on 6/21/12. E12 also acknowledged that she had erroneously administered 2.5 mg of Amlodipine on 6/16/12 through 6/18/12, and 6/20/12. The dose on 6/19/12 was signed off by another nurse. Five (5) doses of Amlodipine administered to R30 were only half of the dose ordered by the physician. The facility failed to ensure that R30 was free of any significant medication errors. During an interview with E2 (Director of Nursing) on 6/21/12, she acknowledged the findings. E2 stated that she had interviewed the nurse who had administered the Amlodipine on 6/19/12 and that the nurse stated that she had given 2 tablets of Amlodipine 2.5 mg (to equal 5 mg). E2 stated the physician had been notified of the error and had reviewed R30's blood pressure readings and had lowered the dose of Amlodipine back to 2.5 mg daily.	F 333		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371		

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F 371	Continued From page 6 under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations made in the dietary department and staff interviews, it was determined that the facility failed to distribute and serve food under sanitary conditions. Findings include: 1. Observation of the first floor dining room on 6/20/12 at 8:12 AM revealed E10 (dietary aide) serving food to residents after touching soiled equipment surfaces in the kitchenette and the dining room without washing her hands. E10 was also observed touching toasted bread with gloved hands that had previously touched different soiled surfaces. Details of the observations were as follows: E10 was observed with gloved hands touching the sneeze guard at the steam table in the middle of the dining room set up as a buffet style, then going in the kitchen to pick up coffee in a cart, then taking bread out of toaster with her soiled gloves; then opening the microwave door, taking an egg plate to a resident (R10), then picking up trash from another table and tossing it, then picking up a plate and taking toast out of toaster with her soiled gloves and giving it to a resident while her thumb with the soiled gloves were on the bread. E10 was then observed touching a chair, moving a resident walker for a resident that had just come in the dining room, and giving	F 371		

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F 371	Continued From page 7 coffee to R10. E10 then went to the dining room kitchenette, removed her gloves and washed her hands for less than 4 seconds, dried her hands with paper towels which she placed into her smock. E10 gloved her right hand and picked up a plate with a muffin from a resident table and placed it in the microwave. She then placed a glove on the left hand and with her soiled gloved right hand she placed toast on a plate, took it to the griddle area, moved a chair, took toast to R33. E10 then washed her hands for approximately 3 seconds, dried them and then turned off the faucet with her bare, clean hands. In an interview with E4 (Food Service Director) on 6/20/12, she agreed that E10 should have washed her hands after handling the toaster, which she had herself observed. Additionally on 6/20/12 during the same dining observation, E4 was observed touching a resident's bare, upper arm, and then she assisted another resident by pushing the chair in and touching the top of the chair. E4 then was observed returning to the griddle and placing liquid pasteurized eggs onto the griddle, and frying the eggs without first washing her hands after touching various soiled surfaces. 2. Observation of the first floor dining room on 6/20/12 at 8:00 AM revealed that the facility failed to distribute food in a sanitary manner when bread was served without the provision of a utensil for residents to use when reaching for bread served in a bag. A utensil for residents to take contents out of the bread bag was not available to prevent contamination.	F 371	E10 and E4 were educated immediately on when to wash hands, apply gloves and safe food handling procedures. *See attachment F* E4 completed Managers Safe Serve course Utensils were supplied for Residents to remove bread from bread bags.	6/20/12 6/30/12 6-21-12

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F 371	Continued From page 8 3. During the dining observation on 6/20/12 at 8:00 AM, two of four bulk cereal containers were observed uncovered and lids up. The cereal remained uncovered. In an interview with E4 on 6/20/12, she confirmed this finding. On 6/21/12 at 12:30 PM, E4 indicated she placed utensil (tongs) out in the dining room and residents used their hands. 4. Observation of the steam table inside the first floor dining room on 6/18/12 at approximately 12:10 PM revealed that all four sneeze guards were in the up position for at least 15 minutes until E11 (Certified Nurse's Aide-CNA) observed this and lowered the sneeze guards. Additionally, observation of the same steam table on 6/18/12 revealed residents and a visitor assisting themselves to food without any monitoring of the steam table by facility staff. Approximately 15 minutes later, other staff were observed going to the steam table to serve resident's that could not get their food themselves from the steam table. In an interview with E11 on 6/20/12, she confirmed the guards should have been down. 5. Observation of the walk-in refrigerator in the kitchen with E4 (Food Service Director) on 6/18/12 at approximately 8:25 AM revealed undated food as follows: 5a. A bag of opened yellow cheese was undated. 5b. A plastic unopened container of imitation crab meat was undated Upon inspection of the Walk-in Freezer on 6/18/12 at 8:30 AM with E4 (Food Service	F 371	The bulk cereal dispenser was replaced in the first floor dining room with a closed bulk cereal dispenser. Sneeze guards were lowered Foods in the walk in refrigerator were dated	6-22-12 6-18-12 6-18-12

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F 371	Continued From page 9 Director), the following was observed: 5c. Two bags of unopened frozen peas were undated. 5d. One bag of mixed vegetables was opened and undated. 5e. Yellow sliced cheese stored in a plastic wrap (not the original wrap) was undated. 5f. Bags of unopened sliced chicken (used by 4/12/12) and a few tubes of ground beef out of their original box were undated. Upon inspection of the Walk-in produce refrigerator on 6/18/12 at 8:35 AM with E4 (Food Service Director), the following was observed: 5g. A dessert rack of at least six trays full of dessert (containing different types of cakes) was undated. 5h. An opened bag of whip cream was undated. E4 stated it should have been dated. Upon inspection of the Dairy refrigerator on 6/18/12 at 8:35 AM with E4 (Food Service Director), the following was observed: 5i. A bag of opened ground yellow cheese was undated. 5j. Three plates with shelled pasteurized eggs (not in their original container) were undated. E4 on 6/18/12 confirmed these findings. 6. Observation of the process of getting/serving lunch on 6/19/12 and breakfast on 6/20/12 in the second floor dining room revealed that food was served by various different individuals. There was no one dietary staff person assigned to monitor the safety of the food distribution and services to ensure food was served under sanitary	F 371	Foods in the walk in freezer were dated Foods in the walk in produce refrigerator were dated Foods in the dairy refrigerator were dated All foods noted to be without labels had been prepared the evening before for the next days use- less than 24 hours. A dietary staff person has been assigned to each unit to monitor food distribution	6-18-12 6-18-12 6-18-12 6-22-12

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F 371	Continued From page 10 conditions. On 6/19/12, lunch was brought into the dining room via a steamer cart by a dietary staff person. The steamer was stationed in one corner of the dining room, however, there was no assigned staff to monitor and to plate the food. The food trays were left uncovered at all times during distribution and served by different staff/individuals.The CNAs and a "pantry aide" went around to residents and asked what they wanted to have and then went to prepare their plates from the steamer and served the food individually. E13 (CNA) would occasionally stop and would interact with the residents and at the same time put her hands on the resident's back and/or on the back of the resident's chair and on the apron she was wearing. There was no handwashing by the staff after touching residents and other surfaces before going to the food steamer to prepare the residents' plate of food. R9 and R31 who sat across from each other were observed coughing frequently. In addition R9's visiting family member also went to serve herself food from the food steamer cart using the serving spoon left at the steamer. A second mealtime observation was done on 6/20/12 at breakfast in the same dining room with E14 (CNA) as one of the staff serving. One resident (unknown name) went to get her own food from the steamer cart via her roller walker. E15 (dietary staff) and E14 (CNA) donned a glove on her right hand to get bread from the bag and toasted the bread. During an interview with E4 (Food Service	F 371	Dietary staff now plate foods. Per surveyors instructions Residents and family members may no longer serve themselves at the buffet. CNA's take orders from Residents and their family members, tell the dietary staff what to plate and take it to the Residents and family members. All Resident have the potential to be affected by food not dated or served under sanitary conditions. Dietary staff were immediately in-serviced on sanitary food service and storage. In servicing continued until all dietary staff were educated. All foods are appropriately dated and labeled. Dietary staff are assigned to oversee food service. Sneeze guard are lowered immediately after food is placed in buffet. The bulk cereal dispenser has been changed to a closed unit and labeled. Residents and family members are no longer permitted to serve themselves from the buffet. *See attachment G*	6-22-12 7-10-12

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F 371	Continued From page 11 Director) on 6/21/12 at approximately 1:00 PM, she stated that the facility's food service system in the dining room was that CNA's and the pantry aides prepare the food plates and serve one at a time to the residents. In addition, the residents are permitted to get their own food from the food steamer by themselves. This finding was discussed with the E9 (Administrator), E2 (DON) and E3 (ADON) on 6/21/12.	F 371	Dietary Supervisor will observe dining room services on a ongoing basis. Refrigerators and freezers will be checked daily to ensure all foods are dated and labeled. Administrative nurse will utilize the Infection Control Spot Check form monthly to ensure proper handwashing and food handling is being done.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	F 431	Infection Control Spot Check results and Dietary Supervisor observations will be reviewed at Quarterly QAPI meetings.	6-28-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A006	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANNE JUGAN RESIDENCE	185 SALEM CHURCH ROAD NEWARK, DE 19713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 12 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to ensure that the drugs and biologicals stored in the medication rooms and medication carts were not expired. Findings include: An observation on 6/21/12 at 1:00PM of the medication room on the Holy Family unit revealed that there were nine Compro 25mg suppositories (Compazine- for nausea) (for R21) in the refrigerator that had an expiration date of 4/12. This was confirmed with E8 (nurse) on 6/21/12 at which time she removed and disposed of them.	F 431	Compazine is not a scheduled or controlled drug. The expired suppositories were removed and disposed of. All medication refrigerators Attachment were immediately checked for expired or discontinued medications. All Residents have the potential to be affected by storage of expired medications. Fortunately the medication was in a locked room and Residents did not have access to it. Nurses were immediately in-serviced on the necessity of removing and destroying expired medications. Formal in service conducted at last Nurses Meeting *See attachment H*	6/21/2012 6/21/12 7-10-12
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441	Refrigerators will be checked for expired medications on the 10th of each month by the 11-7 nurse. *See attachment I* Refrigerators will also be checked monthly by the Consultant Pharmacist or designee and any concerns will be addressed at QAPI quarterly meetings	7/10/12 6-28-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A006	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANNE JUGAN RESIDENCE	185 SALEM CHURCH ROAD NEWARK, DE 19713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 13 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to maintain infection control practices designed to provide a safe, sanitary and comfortable environment, and to help prevent the development and transmission of disease and infection. Findings include:	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A006	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANNE JUGAN RESIDENCE	185 SALEM CHURCH ROAD NEWARK, DE 19713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 14 During a medication pass observation on 6/19/12, E16 (nurse) was observed administering a nebulizer treatment to R19. E16 washed her hands, dried them with a paper towel, used the paper towel to turn off the faucet and then redried her hands using the contaminated paper towel. This occurred twice during the observation. Interview with E16 immediately afterwards confirmed the findings.	F 441	No Residents were affected by E16 re-drying her hands with a contaminated paper towel as she did not touch the medication or the inside of the nebulizer cup and she was washing her hands before leaving the room. E16 was immediately inserviced on proper handwashing. All Residents have the potential to be affected by in-proper hand washing. Nurses have been in-serviced on hand washing and proper procedure for drying hands. Monthly Infection Control Spot Checks will be conducted by a administrative nurse to at least 4 staff members including the nursing and dietary personnel. If necessary immediate in-servicing will be conducted. *See attachment J* Infection Control Spot Check results will be reviewed at QAPI meetings.	6-19-12 7-10-12 7-11-12 next meeting 7-25-12

DELAWARE HEALTH AND SOCIAL SERVICES (DHSS)
Division of Long Term Care Residents Protection (DLTCRP)

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Jeanne Jugan Residence

DATE SURVEY COMPLETED: June 21, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual survey was conducted at this facility from June 18, 2012 through June 21, 2012. The deficiencies contained in this report are based on observations, interviews, review of resident's records and review of other documentation as indicated. The facility census the first day of the survey was 38. The Stage II sample totaled 26 residents.	
3201.1.0	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.2	**Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 6/21/12, F225, F323, F333, F371, F431, and F441.	Cross refer to response to CMS 2567 - L survey report date completed 6/21/11, F225, F333, F371, F431, and F441
3201.7.5	**Kitchen and Food Storage Areas. Facilities shall comply with the 2011**	

Provider's Signature A. Cecile Zeringue Title adm Date 7/13/12

NAME OF FACILITY: Jeanne Jugan Residence

DATE SURVEY COMPLETED: June 21, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Delaware Food Code. **This requirement was not met as evidenced by:** Based on the dietary observations during the survey, it was determined that the facility failed to comply with sections: 2-301.14, 3-501.17, and 3-602.11 of the State of Delaware Food Code. Findings include: **2-301.14 When to Wash.** **FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLESERVICE and SINGLE-USE ARTICLES and:** **(E) After handling soiled EQUIPMENT or UTENSILS;** **(F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks;** **(H) Before donning gloves for working with FOOD; and** **(I) After engaging in other activities that contaminate the hands.** **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed, 6/21/12, F371, example 1. **3-306.11 Food Display.**	Cross refer to CMS 2567 - L survey report date completed 6/21/11, F371 example 1

NAME OF FACILITY: Jeanne Jugan Residence

DATE SURVEY COMPLETED: June 21, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Except for nuts in the shell and whole, raw fruits and vegetables that are intended for hulling, peeling, or washing by the CONSUMER before consumption, FOOD on display shall be protected from contamination by the use of PACKAGING; counter, service line, or salad bar FOOD guards; display cases; or other effective means. P **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed, 6/21/12, F371, Example 3 and 4. **3-306.13 Consumer Self-Service Operations.** **(A) Raw, unpackaged animal FOOD, such as beef, lamb, pork, POULTRY, and FISH may not be offered for CONSUMER self-service.** **This paragraph does not apply to:** **(1) CONSUMER self-service of READY-TO-EAT FOODS at buffets or salad bars that serve FOODS such as sushi or raw shellfish;** **(2) Ready-to-cook individual portions for immediate cooking and consumption on the PREMISES such as CONSUMER-cooked MEATS or CONSUMER-selected ingredients for Mongolian barbecue; or** **(3) Raw, frozen, shell-on shrimp, or lobster.** **(B) CONSUMER self-service operations for READY-TO-EAT FOODS shall be provided with suitable UTENSILS or effective dispensing methods that protect the FOOD from contamination.** **(C) CONSUMER self-service operations**	Cross refer to CMS 2567 - L survey report date completed 6/21/11, F371 example 3 and 4

NAME OF FACILITY: Jeanne Jugan Residence

DATE SURVEY COMPLETED: June 21, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	such as buffets and salad bars shall be monitored by FOOD EMPLOYEES trained in safe operating procedures. Pf **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed, 6/21/12, F371, Example 2 and 4. **3-501.17 Ready-to-Eat, Potentially Hazardous Food (Time/Temperature Control for Safety Food), Date Marking.** **(A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in ¶¶ (D) and (E) of this section, refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days.** **(B) Except as specified in ¶¶ (D) - (F) of this section, refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate**	Cross refer to response to CMS 2567 - L survey report date completed 6/21/11, F371 example 2 and 4

NAME OF FACILITY: Jeanne Jugan Residence

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in ¶ (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; Pf and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. (C) A refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) ingredient or a portion of a refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) that is subsequently combined with additional ingredients or portions of FOOD shall retain the date marking of the earliest-prepared or first prepared ingredient. (D) A date marking system that meets the criteria stated in ¶¶ (A) and (B) of this section may include: (2) Marking the date or day of preparation, with a procedure to discard the FOOD on or before the last date or day by which the FOOD must be consumed on the premises, sold, or discarded as specified under ¶ (A) of this section; (3) Marking the date or day the original container is opened in a FOOD ESTABLISHMENT, with a procedure to discard the FOOD on or before the last date or day by which the FOOD must be consumed on the premises, sold, or discarded as specified under ¶ (B) of	

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	this section; or 87 **(4) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the REGULATORY AUTHORITY upon request.** **(6) Shelf stable, dry fermented sausages, such as pepperoni and Genoa salami that are not labeled "Keep Refrigerated" as specified in 9 CFR 317 Labeling, marking devices, and containers, and which retain the original CASING on the product; and** **(7) Shelf stable salt-cured products such as prosciutto and Parma (ham) that are not labeled "Keep Refrigerated" as specified in 9 CFR 317 Labeling, marking devices, and containers.** **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed, 6/21/12, F371, example 5. **3-602.11 Food Labels.** **(A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers.** **(B) Label information shall include:** **(1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement;** **(2) If made from two or more ingredients, a list of ingredients in**	Cross refer to CMS 2567 - L survey report date completed 6/21/11, F371 example 5

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	descending order of predominance by weight, including a declaration of artificial color or flavor and chemical preservatives, if contained in the FOOD; **(4) The name and place of business of the manufacturer, packer, or distributor; and** **(5) The name of the FOOD source for each MAJOR FOOD ALLERGEN contained in the FOOD unless the FOOD source is already part of the common or usual name of the respective ingredient (Effective January 1, 2006).** **(6) Except as exempted in the Federal Food, Drug, and Cosmetic Act § 403(Q)(3) - (5), nutrition labeling as specified in 21 CFR 101 - Food Labeling and 9 CFR 317 Subpart B Nutrition Labeling.** **(C) Bulk FOOD that is available for CONSUMER self-dispensing shall be prominently labeled with the following information in plain view of the CONSUMER:** **(1) The manufacturer's or processor's label that was provided with the FOOD; or 97** **(2) A card, sign, or other method of notification that includes the information specified under Subparagraphs (B)(1), (2), and (5) of this section.** **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed, 6/21/12, F371, example 5.	Cross refer to CMS 2567 - L survey report date completed 6/21/11, F371 example 5